

4737 CERTIFICATE OF DEATH


Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Stevensville</u>		c. LENGTH OF STAY IN lb <u>90yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Clarence</u> Last <u>Heath</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 7, 1869</u>
9. AGE (In years last birthday) yrs. <u>90</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Charles C Heath</u>		14. MOTHER'S MAIDEN NAME <u>Ellen ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>Mrs. Emma Heath</u>		Address <u>Stevensville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET OF DEATH <u>3 days</u> <u>? yes.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>		DATE SIGNED <u>4/28/59</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt M.D.</u>		ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville, Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Rashfield</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 7 '59</u>	
ADDRESS <u>Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it may be retained by the hospital or attending physician. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4738

CERTIFICATE OF DEATH

Reg. Dist. No.

114725

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED First <u>CHARLES</u> Middle <u>PATRICK</u> Last <u>HORNEY</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 17 - 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NOAH HORNEY</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE SPIELGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. HORNEY</u>		Address <u>GRASONVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>few yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 5</u> , 19 <u>59</u> , and that death occurred at <u>1:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt MD</u>		ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>4/6/59</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 8</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS</u>		22d. LOCATION (City, town, or county) (State) <u>QUEENSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 13 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thacker</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

04726

4739

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Barclay</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Barclay</u>	
c. LENGTH OF STAY IN 1b <u>60 Yrs.</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Kirkwood</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/12/1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>28</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Johnson</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Margaret Johnson Barclay</u>		Address <u>Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Passive Corbolic Poisoning</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Remittent Librillator</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>3 MOS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JAN 7</u> , 19 <u>59</u> , to <u>APR 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>APR 27</u> , 19 <u>59</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Wright</u>		ADDRESS (Street, city or town, state) <u>MARYLAND</u> DATE SIGNED <u>APR 28, 1959</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT H. WRIGHT</u>		<u>GREENSBORO MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Marydel, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaes</u>		ADDRESS <u>Greensboro, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1938

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of burial		19. Signature of burial		20. Signature of burial	
21. Signature of burial		22. Signature of burial		23. Signature of burial		24. Signature of burial	
25. Signature of burial		26. Signature of burial		27. Signature of burial		28. Signature of burial	
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85. Signature of burial		86. Signature of burial		87. Signature of burial		88. Signature of burial	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04727

4740

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROSEANNA F. MOFFETT				4. DATE OF DEATH Month Day Year April 4, 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1915		9. AGE (In years last birthday) yrs. 43	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Newsham				14. MOTHER'S MAIDEN NAME Margaret L. Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address George Moffett, Millington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 526X DUE TO Bronchiectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 days 9 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/25 , 19 59 , to 4/4 , 19 59 , that I last saw the deceased alive on April 3 , 19 59 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE H. H. Hamilton M.D. Millington Md 4/6/59 PHYSICIAN'S NAME (Type) H. H. HAMILTON MILLINGTON, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Old Bohemia Cem.		22d. LOCATION (City, town, or county) (State) Warwick, Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Holloway				24a. REC'D BY REGISTRAR DATE APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. French	

CERTIFICATE OF DEATH

DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
JAN 15 1900		10:30 AM		HOME	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JAN 15 1835		MASSACHUSETTS		UNITED STATES	
MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE COUNTRY	
DISEASE		CAUSE OF DEATH		MANNER OF DEATH	
HEMIPLEGIA		HEMIPLEGIA		NATURAL	
DURATION OF ILLNESS		DATE OF ONSET		DATE OF DEATH	
3 MONTHS		JAN 1 1900		JAN 15 1900	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
NONE		NONE		NONE	
TENDENCY TO SUICIDE		TENDENCY TO MURDER		TENDENCY TO OTHER CRIMES	
NONE		NONE		NONE	
MENTAL CONDITION		MENTAL CONDITION		MENTAL CONDITION	
NORMAL		NORMAL		NORMAL	
PHYSICAL CONDITION		PHYSICAL CONDITION		PHYSICAL CONDITION	
GOOD		GOOD		GOOD	
DIET		DIET		DIET	
REGULAR		REGULAR		REGULAR	
EXERCISE		EXERCISE		EXERCISE	
MODERATE		MODERATE		MODERATE	
SLEEP		SLEEP		SLEEP	
GOOD		GOOD		GOOD	
CLOTHING		CLOTHING		CLOTHING	
ADEQUATE		ADEQUATE		ADEQUATE	
HYGIENE		HYGIENE		HYGIENE	
GOOD		GOOD		GOOD	
MEDICAL ATTENTION		MEDICAL ATTENTION		MEDICAL ATTENTION	
ADEQUATE		ADEQUATE		ADEQUATE	
NURSING ATTENTION		NURSING ATTENTION		NURSING ATTENTION	
ADEQUATE		ADEQUATE		ADEQUATE	
BURIAL		BURIAL		BURIAL	
BY		BY		BY	
NONE		NONE		NONE	
DATE OF BURIAL		DATE OF BURIAL		DATE OF BURIAL	
PLACE OF BURIAL		PLACE OF BURIAL		PLACE OF BURIAL	
COUNTRY OF BURIAL		COUNTRY OF BURIAL		COUNTRY OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESSES		SIGNATURE OF WITNESSES		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	
OFFICIAL CERTIFICATE		OFFICIAL CERTIFICATE		OFFICIAL CERTIFICATE	
DATE OF CERTIFICATE		DATE OF CERTIFICATE		DATE OF CERTIFICATE	
PLACE OF CERTIFICATE		PLACE OF CERTIFICATE		PLACE OF CERTIFICATE	
COUNTRY OF CERTIFICATE		COUNTRY OF CERTIFICATE		COUNTRY OF CERTIFICATE	

CERTIFICATE OF DEATH

04728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ingleside</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ingleside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOUI'S</u> First <u>CARL</u> Middle <u>PLUGGE</u> Last		4. DATE OF DEATH <u>APRIL</u> Month <u>2</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 21-1883</u>
9. AGE (In years last birthday) <u>75</u> yn.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEBRASKA</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Henry Plugge</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Meyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-1107</u>	
17. INFORMANT <u>MRS. PLUGGE</u>		Address <u>INGLESIDE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Quarantine, Chills, undressing in bed</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arterio-Sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>58</u> , to <u>April 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 2</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. McTherson</u> M.D.		DATE SIGNED <u>4/4/59</u>	
PHYSICIAN'S NAME (Type) <u>H. F. McTherson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL 8</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHESTER</u>	22d. LOCATION (City, town, or county) (State) <u>CHESTERTOWN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill Ind.</u>		24a. RECEIVED BY REGISTRAR <u>APR 8 59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoms</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be searched for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Elsworth</u> <u>Middle</u> <u>Rogers</u> <u>Last</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Maxfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>218-30-0981</u>	
17. INFORMANT <u>ANNA L. Rogers, Centreville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis</u> <u>1957</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1956</u> , to <u>April 24, 1959</u> , that I last saw the deceased alive on <u>April 16, 1959</u> , and that death occurred at <u>10:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D.		ADDRESS (Street, city or town, state) <u>Centreville Md.</u> DATE SIGNED <u>4-27-59</u>	
PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 28, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>	22d. LOCATION (City, town, or county) (State) <u>Centreville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Russell</u> <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kinn</u> DATE <u>APR 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

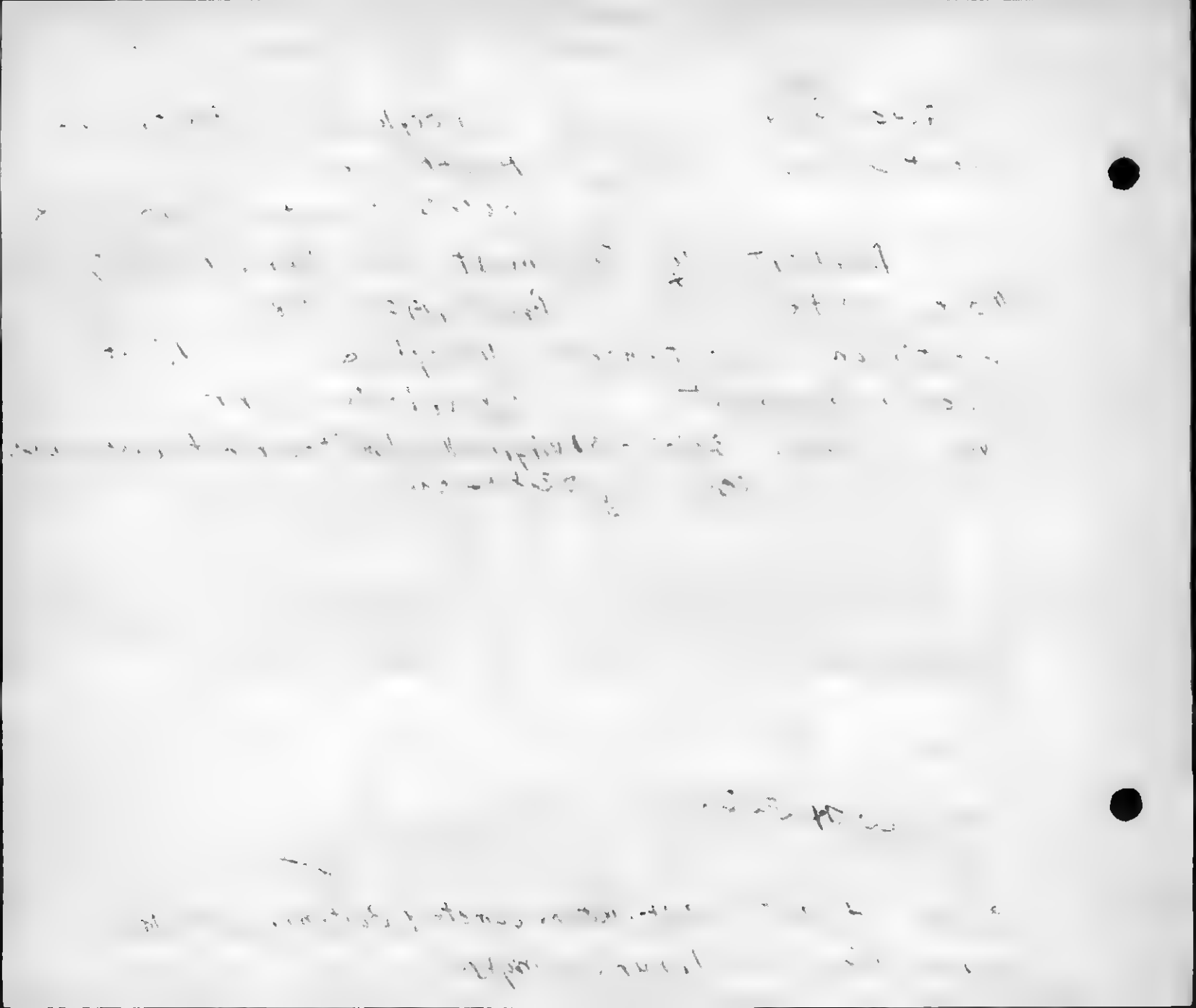
14730

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Queen Ann</u> 4743 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kent Island</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> d. STREET ADDRESS <u>5618 Southwestern Blvd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norbert W. Schmidt</u>		4. DATE OF DEATH Month Day Year <u>April 19, 1959</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 20, 1920</u>		9. AGE (In years last birthday) <u>38</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coast Guard</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred W. Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Derr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>217-09-9321</u>	
17. INFORMANT <u>Virginia M. Schmidt</u>		Address <u>5618 Southwestern Blvd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. H. Fisher</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. NAME OF CEMETERY OR CREMATORY <u>Bolto. National Cemetery</u>	
22b. DATE THEREOF <u>4/23/59</u>		22c. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrue, Inc 1328 Sulphur Spring Rd.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hous</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4744 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 1, 7, Film 2242, 5-15-59, mnd

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels, Md.</u>		
c. LENGTH OF STAY IN Tb <u>6 wks</u>			d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Private Home</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>MARY</u> First Middle Last			4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-20</u>		9. AGE (In years last birthday) <u>39</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph White</u>			14. MOTHER'S MAIDEN NAME <u>Eva Fentress</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John White</u> Address <u>St. Michaels, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>May 2-59</u>	
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cent.</u>	
22d. LOCATION (City, town, or county) <u>St. Michaels, Md.</u>		22e. (State) <u>Md.</u>		22f. (Country) <u>U.S.A.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Schell</u>		ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>Robert E. Thomas</u>	
24b. REGISTRAR'S SIGNATURE		24c. DATE			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4746

CERTIFICATE OF DEATH

04731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL QUEENSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL QUEENSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BESSIE LEE WRIGHTSON</u>				4. DATE OF DEATH Month Day Year <u>APRIL 18 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 13 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>QUEEN ANNE'S Co., Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN F BURNS</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Pratt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>DONE</u>		17. INFORMANT Address <u>Miss Ethel Wrightson, Queenstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute uremia</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>nephrosclerosis, Arteriosclerosis</u> several years (c) <u>hypertensive cardiovascular disease</u> several years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis many years, malnutrition</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>St</u> (County) (State)							
21. I certify that I attended the deceased from <u>March 9, 1959</u> , to <u>April 18, 1959</u> , that I last saw the deceased alive on <u>March 17, 1959</u> , and that death occurred at <u>10:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmair</u> M.D. <u>Stevensville, Md. April 19, 1959</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAYER</u>				STEVENSVILLE MARYLAND			
22a. BURIAL, CREMATION, (REMOVAL) (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 24 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CENTREVILLE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler, Jr. of Butler Bros., Centerville, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1918

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED
RESIDENCE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
DISEASE OR INJURY
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

NAME OF DECEASED	RESIDENCE
DATE OF DEATH	PLACE OF DEATH
CAUSE OF DEATH	DISEASE OR INJURY
MANNER OF DEATH	AGE
SEX	RACE
RELIGION	EDUCATION
OCCUPATION	MARRIAGE
SINGLE	MARRIED
WIDOWED	DIVORCED
REMARKS	